

1633

CERTIFICATE OF DEATH

Reg. Dist. No. 166

Item 9, 11-0179 3-21-55 et

1. PLACE OF DEATH:

COUNTY GARRETT

MD

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

X TOWN SWANTON MD LIFE TIME

HOSPITAL OR INSTITUTE OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MD

COUNTY GARRETT.

CITY (If outside corporate limits, write RURAL and give nearest town)

OR TOWN SWANTON MD.

STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

MARY CATHERINE BITTINGER

4. DATE OF DEATH: FEB. 28 1955

5. SEX:

FEMALE

WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): WIDOWED

8. DATE OF BIRTH:

JAN.-17-1898

9. AGE last birthday:

77 7/16 yrs.

IF UNDER 1 YEAR IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

MS HENRY MD

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME:

SIMEON KNOX.

14. MOTHER'S MAIDEN NAME:

CAROLYN BROWN.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

FRANK BITTINGER SWANTON MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

422.1

Immediate cause

(a)

DUE TO

Congestive heart failure

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b)

DUE TO

Art. C. V. D.

(c)

INTERVAL BETWEEN ONSET AND DEATH

2 mos?

years

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Not while work ☐ at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 55, to Feb. 28, 1955, that I last saw the deceased alive on Feb. 21, 1955, and that death occurred at 3:30 P.M., from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

24. FUNERAL DIRECTOR

REG. BY LOCAL REGISTRAR'S SIGNATURE

ADDRESS

DATE

Julia A. Towan

Emory Boldin OAKLAND MD

MD

MARGIN RESERVED FOR BINDING

RECEIVED

MAR 15 1955

BUREAU V. B.

CERTIFICATE OF DEATH

Reg. Dist. No. 166

Item 12, Film G177 2-14-55 et

1. PLACE OF DEATH - COUNTY Garrett		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE West Virginia		COUNTY Tucker	
CITY (If outside corporate limits, write RURAL and OR give nearest town) Oakland		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) Thomas		85X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Evans Rest Home				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (First) John		(Middle)		(Last) BLACK		4. DATE OF DEATH (Month) (Day) (Year) Feb 5 1953	
5. SEX male		6. COLOR OR RACE white		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married		8. DATE OF BIRTH June 15, 1878	
				9. AGE last birthday 76 yrs.		If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal		11. BIRTHPLACE (State or foreign country) Futchberg, Austria		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Swartz				14. MOTHER'S MAIDEN NAME Mary Polinska			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY No. 232-09-6414		17. INFORMANT AND ADDRESS Mrs. Mary Black			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH										18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
4221 Immediate cause		(a) Congestive Heart Failure								?			
Antecedent cause(s)		(b) Art. C. V. D.								years			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(c)											
II. OTHER SIGNIFICANT CONDITIONS													
Conditions contributing to the death but not related to the disease or condition causing death.										Senility			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION								20. AUTOPSY?			
none										Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT		(Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY)		(STATE)			
SUICIDE		none		OF									
HOMICIDE				INJURY									
TIME (Month) (Day) (Year)		(Hour)		INJURY OCCURRED		HOW DID INJURY OCCUR?							
OF				While at		Not While							
INJURY		m.		Work <input type="checkbox"/>		At work <input type="checkbox"/>							

22. I hereby certify that I attended the deceased from 12/21, 1954, to 2/1, 1955, that I last saw the deceased

alive on 2/1, 1955, and that death occurred at 10:35 P.m., from the causes and on the date stated above.

SIGNATURE _____ (Degree or title) _____ ADDRESS _____ DATE SIGNED _____

2. Pol. Ind. Koll. d. Ind. - 1-1-

23. BURIAL, CREMATION REMOVAL (Specify)		DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial		Feb. 9, 1955	Catholic Cemetery	Thomas	West Va.
DATE RECD BY LOCAL REG.			REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
2/8/1955			[Signature]	[Signature]	Thomas, W. Va.

MARGIN RESERVED FOR BINDING

Vgl. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 10 1911

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1635

CERTIFICATE OF DEATH

Reg. Dist. No. 01621/62

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Garett</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Garett</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
<u>Rural Grantsville</u>	<u>6-Days</u>	<u>Rural Grantsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	

3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>Henry</u>	(Middle) <u>Willis</u>	(Last) <u>Brabson</u>	(Month) <u>2</u> (Day) <u>12</u> (Year) <u>1955</u>
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <u>2-5-1955</u>
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):
			<u>Rural Grantsville Md</u>
13. FATHER'S NAME: <u>George. Harvey. Brabson</u>		14. MOTHER'S MAIDEN NAME: <u>Lena ROSS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.):		17. INFORMANT & ADDRESS:	
		<u>George Harvey Brabson. Grantsville Md</u>	

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
<u>763.0</u>		
Immediate cause		
(a) <u>Pneumonia</u>		
DUE TO		
Antecedent causes(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.		
(b) DUE TO		
(c)		

11. OTHER SIGNIFICANT CONDITIONS		20. AUTOPSY ?	
Conditions contributing to the death but not related to the disease or condition causing death.		Yes <input type="checkbox"/> No <input type="checkbox"/>	
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR ?	

22. I hereby certify that I attended the deceased from 19..... to 19....., that I last saw the deceased alive on 19....., and that death occurred at 5:00 AM, from the causes and on the date stated above.

SIGNATURE John F. Whitehill, Jr. M.D. ADDRESS Grantsville, Md. DATE SIGNED 2-12-55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF 2-14-1955 NAME OF CEMETERY OR CREMATORY Grantsville LOCATION (City, town, or county) (State) Grantsville Md

DATE REC'D BY LOCAL REGISTRAR 2-14-1956 REGISTRAR'S SIGNATURE Edith Broadwater 24. FUNERAL DIRECTOR Wm Winterberg ADDRESS Grantsville Md

4025336364

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 18 1935
BUREAU V. S.

1636

CERTIFICATE OF DEATH

Reg. Dist. No. 01622
162

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Garett</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Garett</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural Grantsville</u>		LENGTH OF STAY (in this place) <u>6 Years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural Grantsville</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED:				4. DATE OF DEATH:			
(First) <u>Thomas</u>		(Middle) <u>Henry</u>		(Last) <u>Brennamon</u>		(Month) <u>2</u> (Day) <u>24</u> (Year) <u>1955</u>	
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Singel</u>		8. DATE OF BIRTH: <u>11-14-1873</u>	
9. AGE last birthday: <u>81</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Rural Bittinger Md</u>		11. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
12. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>Retired Farmer</u>				13. KIND OF BUSINESS OR INDUSTRY: <u>Was Owner</u>			
14. FATHER'S NAME: <u>Joel Brennamon</u>				15. MOTHER'S MAIDEN NAME: <u>Catherine Bittinger</u>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)				17. SOCIAL SECURITY No.: <u>None</u>			
18. INFORMANT & ADDRESS: <u>Frank Brennamon Bittinger Md</u>							
19. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>331X</u> Immediate cause (a) <u>Cerebral hemorrhage</u> Antecedent causes (s) (b) <u>arteriosclerosis, hypertension</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <u>coronary insufficiency</u>							
20. INTERVAL BETWEEN ONSET AND DEATH: <u>1 day</u>							
21. OTHER SIGNIFICANT CONDITIONS: <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>							
22. DATE OF OPERATION: <u>1955</u> 23. MAJOR FINDINGS OF OPERATION: <u>coronary insufficiency</u>							
24. AUTOPSY? <u>Yes</u> <input type="checkbox"/> <u>No</u> <input type="checkbox"/>							
25. ACCIDENT SUICIDE HOMICIDE (Specify)		26. PLACE (Home, farm, factory, street, office bldg., etc.)		27. (CITY OR TOWN)		28. (COUNTY)	
29. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>10/16</u> <u>54</u> m.		30. INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		31. HOW DID INJURY OCCUR?			
32. I hereby certify that I attended the deceased from <u>1955</u> , to <u>2/23</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>2/23</u> , 19 <u>55</u> , and that death occurred at <u>5:20 a.m.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Edith Broadwater</u>				DATE SIGNED <u>2/25/55</u>			
33. ADDRESS		34. ADDRESS					
<u>Grantsville Md</u>		<u>Grantsville Md</u>					
35. BURIAL, CREMATION, REMOVAL (Specify)		36. DATE THEREOF		37. NAME OF CEMETERY OR CREMATORY		38. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2-27-1955</u>		<u>Bittinger Cemetary</u>		<u>Bittinger Garrett Co. Md</u>	
39. DATE REC'D BY LOCAL REGISTRAR		40. REGISTRAR'S SIGNATURE		41. FUNERAL DIRECTOR		42. ADDRESS	
<u>2/25/55</u>		<u>Edith Broadwater</u>		<u>Wm Winterberg</u>		<u>Grantsville Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 28 1955

BUREAU V. S.

1637

CERTIFICATE OF DEATH

Reg. Dist. No. 166

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>GARRETT</u> <u>MD.</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>OAKLAND</u> <u>MD.</u> TOWN <u>OAKLAND</u> <u>MD.</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS			STATE <u>MD</u> COUNTY <u>GARRETT</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>OAKLAND</u> <u>MD.</u> TOWN <u>OAKLAND</u> <u>MD.</u> STREET ADDRESS (If rural, give location)		
3. NAME OF DECEASED: (Type or Print) <u>CHARLES ELLWORTH DAWSON</u>			4. DATE OF DEATH: <u>FEB 24</u> 19 <u>55</u>		
5. SEX: <u>MALE</u>	6. COLOR OR RACE: <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>	8. DATE OF BIRTH: <u>OCT. - 8 - 1879</u>		9. AGE last birthday: <u>75</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>RETIRED WOODMAN.</u>			10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>AMBOY W.VA.</u>
13. FATHER'S NAME: <u>ABRAHAM DAWSON.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO.</u>			16. SOCIAL SECURITY No.: <u>233-34-4040A.</u>		
17. INFORMANT & ADDRESS: <u>CHESTER DAWSON MTLAKPARK MD</u>					

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH		
331X Immediate cause (a) <u>Cerebral Hemorrhage</u>			<u>3 days</u>		
Antecedent cause(s) (b) <u>Arteriosclerotic Hypertension</u>			<u>Several years</u>		
(c) <u>Coronary Disease</u>			<u>Several years</u>		
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION: <u>0</u>			19b. MAJOR FINDINGS OF OPERATION:		
21. ACCIDENT (Specify) <u>SUICIDE</u>			PLACE (Home, farm, factory, street, office bldg., etc.)		
HOMICIDE			INJURY		
TIME (Month) (Day) (Year) (Hour) OF INJURY			INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
22. I hereby certify that I attended the deceased from <u>Feb 22 1955</u> , to <u>Feb 23 1955</u> , that I last saw the deceased alive on <u>Feb 22 1955</u> , and that death occurred at <u>9:40 p.m.</u> , from the causes and on the date stated above.			20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
SIGNATURE <u>Charles E. Smith MD</u>			DATE SIGNED <u>Mar 7 1955</u>		
23. BURIAL, CREMATION REMOVAL (Specify): <u>BURIAL</u>			DATE THEREOF <u>FEB-27-1955</u>		
NAME OF CEMETERY OR CREMATORY <u>GORTNER CEMETERY</u>			LOCATION (City, town, or county) <u>NEAR OAKLAND MD.</u>		
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>Feb 27 1955</u>			FUNERAL DIRECTOR <u>Emory Baldwin</u>		
			ADDRESS <u>OAKLAND MD.</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 15 1955

RECEIVED

1638

CERTIFICATE OF DEATH

Reg. Dist. No. 16

1. PLACE OF DEATH:

COUNTY Garrett

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town)

X TOWN Rural, near Oakland

LENGTH OF STAY
(in this place)
Life timeHOSPITAL OR
INSTITUTION OR
STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Garrett

CITY (If outside corporate limits, write RURAL and give nearest town)
OR TOWN Rural, near Oakland, Md. XSTREET ADDRESS (If rural, give location)
13. NAME OF
DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

Leroy

Friedman

4. DATE

(Month)

(Day)

(Year)

OF

DEATH: Feb. 1, 1955

5. SEX:

Male

6. COLOR OR

RACE:

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED.
(Specify):

Married

8. DATE OF BIRTH:

Apr. 22, 1876

9. AGE last birthday:

77 yrs.

IF UNDER 1 YEAR IF UNDER 24 HRS.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of
work done during most of working life,
even if retired):

Farmer

10b. KIND OF BUSINESS OR
INDUSTRY:

11. BIRTHPLACE (State or foreign country):

near Oakland, Md.

12. CITIZEN OF WHAT
COUNTRY?

U.S.

13. FATHER'S NAME:

John W. Friend

14. MOTHER'S MAIDEN NAME:

Rachel Frye

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of
service)

16. SOCIAL SECURITY No.:

214-16-2730

17. INFORMANT & ADDRESS:

Mr. Leifman Friedman, 1111

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

490X
Immediate cause

(a) Acute Toxic Pneumonia (right)

INTERVAL BETWEEN
ONSET AND DEATH

1 day

Antecedent cause(s)

Diseases or conditions, if any,
giving rise to the above cause
stating underlying cause last

(b) DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not
related to the disease or condition causing death.

Hypertensive Heart Disease

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒21. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,
OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF INJURYINJURY OCCURRED
While at work ☐ Not while
at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 7, 1955 to Feb. 7, 1955, that I last saw the deceased
alive on Feb. 7, 1955, and that death occurred at 7:00 p.m., from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE) ADDRESS

DATE SIGNED

23. BURIAL, CREMATION
REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE RECD BY LOCAL
REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

BUREAU V. S.

VS. A15

1. PLACE OF DEATH: COUNTY GARRETT MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE WEST VIRGINIA COUNTY PRESTON	
CITY (If outside corporate limits, write RURAL and give nearest town) CAKLAND		CITY (If outside corporate limits, write RURAL and give nearest town) TERRA ALTA	
TOWN		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS GARRETT COUNTY MEMORIAL HCSP.		STREET ADDRESS ROUTE # 3	
3. NAME OF DECEASED (Type or Print) LEONARD		4. DATE OF DEATH FEBRUARY 17 1955	
(First) (Middle) (Last)		(Month) (Day) (Year)	
5. SEX M		6. COLOR OR RACE W	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) M		8. DATE OF BIRTH 10-27-1874	
9. AGE last birthday 80 yrs.		10. BIRTHPLACE (State or foreign country) WEST VIRGINIA	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GCFF, MARTIN VANBUREN		14. MOTHER'S MAIDEN NAME NEOMA ELLER HARSH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY No. 705-09-7955	
17. INFORMANT AND ADDRESS LEONARD H. GCFF, ROUTE # 3 TERRA ALTA, W. VA.		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
443X Immediate cause		3 days	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		20 years	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		5 years	
19a. DATE OF OPERATION		20. AUTOPSY	
19b. MAJOR FINDINGS OF OPERATION		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE - HOMICIDE (Specify)		PLACE (Home, farm, factory, street, or office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 1, 1950, to Feb 17, 1955, that I last saw the deceased alive on Feb 17, 1955 and that death occurred at 8:55 p.m., from the causes and on the date stated above.			
SIGNATURE: M. Dorcas Clark Harley, M.D. - Terra Alta W. Va. Feb 18 55		ADDRESS DATE SIGNED	
23. BURIAL, CREMATION REMOVAL (Specify)		LOCATION (City, town, or county) (State)	
DATE THEREOF Feb. 20, 1955		near Boredman, W. Va. Preston County	
NAME OF CEMETERY OR CREMATORY Wedger-Rhodes Cemetery		Terra Alta, W. Va.	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR	
Feb 20/55		Terra Alta, W. Va.	

RECEIVED

MAR 15 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1640

CERTIFICATE OF DEATH

Reg. Dist. No.

01624

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Garrett</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Garrett</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>X</u> TOWN <u>Bloomington</u>	LENGTH OF STAY (In this place) <u>50 Yrs</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bloomington</u>	<u>X</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Unincorporated</u>		STREET ADDRESS (If rural give location) <u>/</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Benton</u> <u>Harshbarger</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Feb.</u> <u>19</u> <u>19 55</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>Jan. 15, 1869</u>
9. AGE last birthday <u>86</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Miner</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Coal Mine</u>	11. BIRTHPLACE (State or foreign country): <u>Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME: <u>Samuel Harshbarger</u>	
14. MOTHER'S MAIDEN NAME: <u>Wm J. Yaste</u>		15. WAR DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>00</u>		17. INFORMANT & ADDRESS: <u>Mrs. Benton Harshbarger, Bloomington,</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Coronary heart failure</u>			<u>4 yrs</u>
ANTECEDENT CAUSE (S) (B) <u>Hypertensive arteriosclerotic heart disease</u>			<u>30 yrs</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from ... , 1946, to <u>Feb. 19 1955</u> , that I last saw the deceased alive on <u>Feb 19, 1955</u> , and that death occurred at <u>5 P</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Samuel Harshbarger Jr</u>		DATE SIGNED <u>2-21-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/20/55</u>	NAME OF CEMETERY OR CREMATORY <u>Bloomington Cem.</u>
LOCATION (City, town, or county) (State) <u>Bloomington, Md.</u>		24. FUNERAL DIRECTOR ADDRESS <u>E.S. Boal, Westernport, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2-21-55</u>		REGISTRAR'S SIGNATURE <u>Wm J. Yaste</u>	

BUREAU V. S.

FEB 1955

ED

MARYLAND STATE DEPARTMENT OF HEALTH

1641

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

01625

166

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY GARRETT		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE GARRETT		COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN OAKLAND				TOWN OAKLAND		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS GARRETT COUNTY MEMORIAL				STREET ADDRESS		(If rural, give location)	
3. NAME OF DECEASED (Type or Print)		(First)		(Middle)		(Last)	
GAY		WILLARD		HAYDEN			
4. DATE OF DEATH		(Month)		(Day)		(Year)	
2		13		1955			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH	
MALE		WHITE		WIDOWER		JUNE 5, 1887	
9. AGE last birthday		If under 1 year		If under 24 hrs.			
67 yrs.		Months		Days		Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
RETIRED		B & O		OAKLAND, MARYLAND			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		17. INFORMANT AND ADDRESS		MT. LAKE PARK,	
JAMES HAYDEN				WILLARD HAYDEN, MARYLAND			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No. (If yes, give war or dates of service)		17. INFORMANT AND ADDRESS		MT. LAKE PARK,	
		105-05-1766		WILLARD HAYDEN, MARYLAND			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Hemorrhage

Antecedent cause(s) (b) Hypertension

Disorders or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Arterio Sclerosis

INTERVAL BETWEEN
ONSET AND DEATH

2 wks

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not
related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify)

SUICIDE

HOMICIDE

PLACE (Home, farm, factory, street,
OF office bldg., etc.)

INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)

OF

INJURY

INJURY OCCURRED
While at Not While
Work ☐ At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1945, to 2-13-1955, that I last saw the deceased

alive on 2/12, 1955, and that death occurred at 8:05 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Dr. E. I. Bauman

M.D.

Barbours

2/13/55

23. BURIAL, CREMATION, or other disposal
REMOVAL (Specify)

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

2/14/55

Julia J. Jorgensen

Emory Bolden

OAKLAND

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

123



02699

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1642

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH:

COUNTY

GARRETT

MD

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

X TOWN CRELLIN MD

HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

MD

COUNTY

GARRETT

CITY (If outside corporate limits, write RURAL and give nearest town)

OR TOWN

CRELLIN

MD X

STREET ADDRESS

(If rural, give location)

1

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

KAREN

THERESE

KENDALL

4. DATE OF DEATH:

(Month)

(Day)

(Year)

FEB

21

1953

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR IF UNDER 24 MRS.

FEMALE WHITE

FEB-28-1954

Yrs. 11 21

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

OAKLAND MD

U.S.

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

SAMUEL KENDALL

MARY ALICE VAN HOOSE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS:

SAMUEL KENDALL

CRELLIN MD

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

(a).....

DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b).....

DUE TO

(c).....

INTERVAL BETWEEN ONSET AND DEATH

3 days

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Not while work ☐ at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at....., from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

FEB-23-1953

OAKLAND CEMETERY

OAKLAND

MD

FEB 23 1953

Julia A. Homan

Emory Bolden

OAKLAND

MD

2024242303

MARGIN RESERVED FOR BINDING

VS. A15 8-51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 15 1955

BUREAU V. S.

1643

CERTIFICATE OF DEATH

Reg. Dist. No. 167

1. PLACE OF DEATH:

COUNTY

GARRETT.

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

X TOWN RURAL OAKLAND MD.

LENGTH OF STAY (in this place)

2 WEEKS.

HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MD

COUNTY GARRETT.

CITY (If outside corporate limits, write RURAL and give nearest town)

OR TOWN RURAL OAKLAND MD.

STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

HATTIE VICTORIA LLOYD.

4. DATE OF DEATH:

(Month) (Day) (Year)

FEB- 19 1955.

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH:

9. AGE last Birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.

FEMALE WHITE

MARRIED JUNE-14-1886

68 yrs. Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

COLUMBIA FURNACE, VA.

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME:

JAMES MINNICK.

14. MOTHER'S MAIDEN NAME:

SARAH MILLER.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

FRANK LLOYD. GORMANIA W. VA.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

420.0 Immediate cause

(a) DUE TO

Coronary Heart Disease

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO

arterio Sclerotic Heart Disease

(c)

INTERVAL BETWEEN ONSET AND DEATH

3 years

8 years

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Not while work ☐ at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8:20 PM 1949, to 1:57 PM, 1955, that I last saw the deceased alive on 1:57 PM, 1955, and that death occurred at 8:15 A.M., from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE) ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE RECD BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

2-15-55

Oliver C. Sheffer

Emory Bolden

OAKLAND MD.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 3 1955

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 027016

Items 8, 9, 11, 12, 17, 19, 20-22-55 et

1. PLACE OF DEATH:

COUNTY GARRETT MARYLAND
CITY (If outside corporate limits, write RURAL LENGTH OF STAY OR and give nearest town) OAKLAND MD
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MD COUNTY GARRETT
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN OAKLAND MD
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

5. SEX:

MALE

WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED

8. DATE OF BIRTH:

OCT. - 9 - 1885

4. DATE OF DEATH:

(Month)

(Day)

(Year)

FEB 25

19 55

9. AGE last birthday:

IF UNDER 1 YEAR

IF UNDER 24 HRS.

69 yrs.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

RETIRED TELEGRAPHER

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): DEER PARK MD.

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME:

JOSEPH MURPHY

14. MOTHER'S MAIDEN NAME:

MARY CONNER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

NO

16. SOCIAL SECURITY No.: 17. INFORMANT & ADDRESS:

705-05-824 ESTELLE MURPHY OAKLAND MD

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

422.1

Immediate cause

DUE TO

Myocardial Heart Disease

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

DUE TO

arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

4 years

8 years

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office hldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 19 1955 to Feb. 24 1955, that I last saw the deceased alive on 23 Feb, 1955, and that death occurred at 11:30 A.m., from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE) ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

BURIAL

FEB-28-1955

OAKLAND CEMETERY

OAKLAND

MD.

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

2/28/1955

Gulian A. Towan

Emory Baldwin

OAKLAND

MD.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 15 1955
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct name is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1645

CERTIFICATE OF DEATH

02702

Item 7, Filmgl79 3-25-: et

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Garrett</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Gar</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Sarmama-Rural</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Sarmama</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>(Backbow Mountain)</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>TONY</u>	(Middle) <u>JOHN</u>	(Last) <u>REPETSKY</u>	(Month) <u>Feb</u> (Day) <u>10</u> (Year) <u>1955</u>
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>Nov. 1878</u>
9. AGE last birthday: <u>76</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>LITHUANIA</u>	
11. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <u>MINER</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>STANLEY REPETSKY</u>		14. MOTHER'S MAIDEN NAME: <u>UNKNOWN</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No.</u>		16. SOCIAL SECURITY No.: <u>232-09-0475</u>	
17. INFORMANT & ADDRESS: <u>HELEN REPETSKY</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death	
Immediate cause <u>422.1</u>		<u>1 week</u>	
Antecedent causes (s) <u>Longestine heart failure</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. <u>Art. C.V. D.</u>			
11. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death <u>chronic Bronchitis</u>			
19a. DATE OF OPERATION: <u>none</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? <u>Yes</u> <input type="checkbox"/> <u>No</u> <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>none</u>		PLACE (Home, farm, factory, street, office bldg., etc.)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7 AM</u> , 19 <u>55</u> , to <u>8 Feb</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>8 Feb</u> , 19 <u>55</u> , and that death occurred at <u>3 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Thomas J. Gentry M.D.</u>		DATE SIGNED <u>2/10/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>2/12/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Catholic</u>		LOCATION (City, town, or county) (State) <u>Thomas, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2/12/55</u>		FUNERAL DIRECTOR <u>J. D. Duncan</u>	

RECEIVED

MAR 15 1955

BUREAU V. S.

1646

CERTIFICATE OF DEATH

Reg. Dist. No. 166

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Garrett</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Garr</u>
CITY (If outside corporate limits, write OR and nearest town) <u>Cahland</u>	RURAL LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write OR and nearest town) <u>Cahland - Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Evans Nursing Home</u>		STREET ADDRESS (If rural give location) <u>X</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>MARY</u>	(Middle) <u>S</u>	(Month) <u>Feb</u>	(Day) <u>5</u>
(Type or Print)		(Year) <u>1955</u>	
5. SEX: <u>FEMALE</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH: <u>MAR 19, 1864</u>
9. AGE last birthday: <u>90</u> yrs.		10. MONTHS <u>2</u> DAYS <u>5</u> HOURS <u>5</u> MIN.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>AURORA WVA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>David Watring</u>		14. MOTHER'S MAIDEN NAME: <u>LOUISE WAITZ</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:	
		17. INFORMANT & ADDRESS: <u>DAVID SHAFFER</u>	

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
422.1 Immediate cause (a) <u>Congestive heart failure</u>		<u>not?</u>
Antecedent causes (s) (b) <u>A.H.C.U.D.</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c)		
11. OTHER SIGNIFICANT CONDITIONS		
Conditions contributing to the death but not related to the disease or condition causing death. <u>Senility</u>		
19a. DATE OF OPERATION: <u>none</u>		19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
21. ACCIDENT (Specify) <u>none</u>		22. I hereby certify that I attended the deceased from <u>19 Nov. 47</u> , to <u>5 Feb., 1955</u> , that I last saw the deceased alive on <u>1 Feb., 1955</u> , and that death occurred at <u>10:20 AM</u> from the causes and on the date stated above.
SUICIDE <u>none</u>		SIGNATURE <u>Thomas J. Gish M.D.</u> DATE SIGNED <u>5 Feb 55</u>
HOMICIDE <u>none</u>		ADDRESS <u>Cahland Md</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY		PLACE (Home, farm, factory, street, office bldg., etc.)
INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>FEB 8, 55</u>
NAME OF CEMETERY OR CREMATORY <u>CARMEI CEMETERY</u>		LOCATION (City, town, or county) (State) <u>AURORA, PRESTON, WVA.</u>
DATE REC'D BY LOCAL REGISTRAR <u>2/7/55</u>		REGISTRAR'S SIGNATURE <u>Julian J. Goyen</u>
24. FUNERAL DIRECTOR <u>Wayne C. Spiggle</u>		ADDRESS <u>Louis, W. Va.</u>

MARGIN RESERVE FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
1647 CERTIFICATE OF DEATH

Reg. Dist. No. 016286

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY	Garrett	STATE	West Virginia
CITY (If outside corporate limits, write RURAL OR and give nearest town)	Oakland	CITY (If outside corporate limits, write RURAL OR and give nearest town)	Monongahela
LENGTH OF STAY (in this place)	2 yrs.	STREET ADDRESS	Communtzie Apt. High Street
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH: (Month) (Day) (Year)	
Chester L. Walls		Feb. 7, 1955	
5. SEX:	5. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:
Male	White	Widowed	1/22/1867
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired.		10b. KIND OF BUSINESS OR INDUSTRY:	12. CITIZEN OF WHAT COUNTRY?
Retired Farmer		Own Farm	U.S.A.
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
A. F. Walls		Elizabeth Adams	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS:	
no		Mrs. Bess Cuppett Oakland, Md.	

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
422.1 Immediate cause		7 days
(a) Cerebrovascular Accident		
Antecedent causes (s)		years
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.		
(b) Art. C. V. D.		
(c)		
11. OTHER SIGNIFICANT CONDITIONS		
Conditions contributing to the death but not related to the disease or condition causing death.		
Senility		
19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
None		
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from 10/8/53, 19....., to 2/7/55, 19....., that I last saw the deceased alive on 2/7, 1955, and that death occurred at 10:15 P M, from the causes and on the date stated above.		
(SIGNATURE) Thomas J. Lynch M.D.		DATE SIGNED 2/8/55
23. BURIAL, CREMATION, REMOVAL (Specify)		NAME OF CEMETERY OR CREMATORY
Burial	DATE THEREOF 2/10/1955	Fairview Cemetery
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE		LOCATION (City, town, or county) (State)
2/8/55		Pisgah, Preston Co., W. Va.
24. FUNERAL DIRECTOR		ADDRESS
Julius H. Rozeau		Herbert C. Leighton Oakland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU A. S.

FEB 1 1954

RECEIVED

MARYLAND

1648

01629

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 172

1. PLACE OF DEATH COUNTY GARRETT MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE MARYLAND COUNTY GARRETT	
CITY (If outside corporate limits, write RURAL and give nearest town) KITZMILLER		CITY (If outside corporate limits, write RURAL and give nearest town) KITZMILLER	
TOWN KITZMILLER		TOWN KITZMILLER	
HOSPITAL OR INSTITUTION OR STREET ADDRESS W. MAIN ST.		STREET ADDRESS (If rural, give location) W. MAIN STREET	
3. NAME OF DECEASED (Type or Print) ORA MAUD WEICHT		4. DATE OF DEATH (Month) FEB. (Day) 15, (Year) 1955	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH JAN. 7, 1882
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR OWN home	9. AGE last birthday 73 yrs. If under 1 year: Months 1 Days 8 Hours Mins.
11. BIRTHPLACE (State or foreign country) Hampshire Co., W. Va.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME DAVID WINFIELD ARNOLD		14. MOTHER'S MAIDEN NAME MOLLY EVERETT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) NO		16. SOCIAL SECURITY No. NONE	
17. INFORMANT AND ADDRESS RONALD D. WEICHT, HAGERSTOWN, MD.			

18. MEDICAL CERTIFICATION
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

442X

Immediate cause

(a)

Acute Myocardial Infarction

Antecedent cause(s)

(b)

Cardio-Vascular Renal Disease

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

3 days

5 years

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from *Jan*, 1950, to *Feb. 15*, 1955 that I last saw the deceased alive on *Feb. 15*, 1955, and that death occurred at *1:45 P.m.*, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION OR OTHER DISPOSAL (Specify)

DATE **2/17/55**NAME OF CEMETERY OR CREMATORY **I.O.O.F. CEMETERY**LOCATION (City, town, or county) **ELK GARDEN, W. Va.**

(State)

DATE REC'D BY LOCAL REG **2/16/55**REGISTRAR'S SIGNATURE *C. W. Barwick*

24. FUNERAL DIRECTOR

ADDRESS **OTHA F. SHARPLESS, BLAINE, W. Va.**

MARGIN RESERVED FOR BINDING

RECEIVED
FEB 21 1955
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01630

1649

CERTIFICATE OF DEATH

Reg. Dist. No. 166

Item 9, film 177 2-15-55 et

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Garrett</u>		MARYLAND		STATE <u>MD</u> COUNTY <u>GARRETT</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Oakland</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>OAKLAND</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>BESSIE HADDON ZAHN</u>				<u>Feb 3 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>FEMALE</u>	<u>WHITE</u>	<u>WIDOWED</u>	<u>FEB-18-1869</u>	<u>85 8/6</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>UNIONTOWN PA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME: <u>JOHN HADDON</u>				14. MOTHER'S MAIDEN NAME: <u>ELLEN HOOK</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If yes, give war or dates of service)				16. SOCIAL SECURITY No.:			
				17. INFORMANT & ADDRESS: <u>MISS VIRGINIA MARSHALL UNIONTOWN. PA.</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
422.1 Immediate cause (a) <u>Art. C. V. D. Heart Failure</u>						<u>years</u>	
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last							
DUE TO							
DUE TO							
(c)							
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death <u>Senility & Arthritis</u>							
19a. DATE OF OPERATION:						19b. MAJOR FINDINGS OF OPERATION:	
						20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
SUICIDE		HOMICIDE		INJURY			
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED		HOW DID INJURY OCCUR?			
OF INJURY		While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>30 Nov 47</u> , 19 <u>47</u> , to <u>2/3</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/23</u> , 19 <u>54</u> , and that death occurred at.....m., from the causes and on the date stated above.							
SIGNATURE <u>Thomas J. C. M. D.</u>				(DEGREE OR TITLE) ADDRESS <u>Oakland, Md</u>		DATE SIGNED <u>2/4/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>FEB-5-1955</u>		<u>OAKLAND CEMETERY</u>		<u>OAKLAND MD.</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>2/5/55</u>		<u>Julius H. Brown</u>		<u>Emory Bolden</u>		<u>OAKLAND MD.</u>	

RECEIVED
FEB 10 1923
BUREAU V. S.